WORLD HEALTH ORGANIZATION

TOBACCO ALERT

JULY 1991

EDITORIAL

ACTIVE STRUGGLE AGAINST SMOKING IN FRANCE

In all countries of the world, smoking is becoming a more worrying public health problem. Tobacco consumption in France, which has been rising steadily at a rate of 4% a year since the beginning of the century, seems to have stabilized over the last few years. But this stabilization is far from reassuring, because the damaging effects only become measurable several years or even decades after the start of tobacco poisoning, and consumption has reached a very high level. It is feared that there will be a further increase in mortality rates from lung cancer, cancer of the upper digestive tracts and cardiovascular disease, and in severe and disabling morbidity associated with chronic bronchitis and respiratory insufficiency. At present more than 50 000 French people die each year from smoking.

Although women still smoke less than men (33% against 48%), it is worrying to note that young girls have adopted practically the same smoking behaviour as boys in the same age group. The long-term consequence will be a significant rise in mortality from lung cancer among women, as has already been seen in the United States.

France has therefore decided to adopt a tough policy to tackle this problem. In order to reduce this fatal endemic disease tomorrow, it is essential to commit the resources today to change the images associated with tobacco consumption, and to ensure that young non-smokers are not pushed into becoming smokers.

This involves eliminating product promotion so as to prevent people taking up smoking as result of advertising, which directly or indirectly strives to make young people associate cigarettes with social success, adventure and freedom, whereas in fact they result in alienation and are a deadly poison. The law passed very recently by the French Parliament for the elimination of all types of tobacco advertising, whether direct or indirect, is an essential step towards this goal.

Non-smoking should also be encouraged by showing respect for the non-smoker: by banning smoking in public places and on public transport in particular (this is already in operation on domestic flights and suburban trains), by setting aside designated areas for smokers rather than for non-smokers, i.e., reversing the present state of affairs and making the public aware that non-smoking is the normal way to behave and that smoking is to be avoided.

The positive image of the liberated, emancipated smoker must gradually disappear.

Of course, this will all take time, but to tackle this serious problem, and ensure the health of future populations and generations, it is essential that this policy, which lies within the framework of the European Community and follows WHO recommendations, should be carried out and complemented by other measures such as an increase in the price of tobacco, help in giving up smoking and health education.

Claude Evin
Minister of Solidarity, Health and Social Protection, between May 1988 and May 1991, during which time the law on tobacco control was passed in France.

NEWS BRIEFS

ANTI-SMOKING LAW IN MOROCCO

The fight against smoking is making swift progress in the countries of the Third World. The Moroccan Parliament has just given striking proof of this by adopting a law which bans smoking in public buildings and prohibits cigarette advertising in the official media and in the street. This decision is all the more remarkable in that the State itself will suffer, since it derives substantial revenue from the sale of tobacco.

The opposition was demanding much more stringent measures, however, in particular a ban on the sale of tobacco to people under 18 years of age and punishments for anyone lighting up a cigarette in a shop, café or football stadium. According to recent statistics, 39% of the male population and 9% of young people are smokers.

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SOCIETY

AFRICA'S APPROACHING CIGARETTE EPIDEMIC

Until recent years both lung cancer and coronary heart disease were rarely found in many black African countries, and the evidence for this was recorded in several careful studies.

In Ibadan, Nigeria in 1960-1963 only five out of 318 cancers in men (less than 2%) and five out of 330 cancers in women were of the lung. In Kampala in 1952-1953 only nine out of 465 cancers in men were pulmonary. No lung cancers were recorded amongst 335 female cancer patients. In Mozambique between 1944 and 1957 only three of 842 male cancers were of the lung and there were no lung cancers reported in 431 women.

By contrast, lung cancer has been reported more frequently in black South Africans. Amongst 171 male cancer patients 7.7% of urban and 7.4% of rural subjects had lung cancer. The age-adjusted lung cancer incidence in black Durban residents in 1969 was 24.0 per 100 000 compared with 37.7 per 100 000 in four regions in the United Kingdom. Almost 10% of cancers in Bantu Johannesburg residents were of the lung. An article in the ***British Medical Journal*** reported 32 cases of lung cancer in African males in Zimbabwe in 1968 of whom almost 90% were cigarette smokers compared with one-fifth of the controls.

Similarly, coronary heart disease was virtually absent in East Africa. No cases of CHD (Coronary heart disease) were found in 1 000 autopsies in Kenya in 1936-1937, and only one of myocardial infarction was recorded in 2 994 autopsies carried out in Kampala between 1931 and 1946. In the United Republic of Tanzania, only five out of 226 hospital admissions for heart disease between 1956 and 1966 were diagnosed as *"atherosclerotic degenerative disease"*. Even in South Africa coronary heart disease was rarely found in the black population.

Although few recent surveys of lung cancer or coronary heart disease have been carried out, there are a number of reports suggesting an increase of both conditions in black Africans. In the 1960s about six cases of lung cancer were admitted to the Jomo Kenyatta teaching hospital in Nairobi each year, whereas in the 1980s over 40 cases were admitted yearly.

In Khartoum, coronary heart disease was rarely diagnosed 30 years ago, but today it is estimated to be one of the commonest causes of death in the professional and business community. Likewise in Nairobi, where there has always been a high prevalence of CHD among Asians, more cases are now being recognized in the native Africans.

This changing pattern of disease clearly needs to be confirmed by detailed clinical and post mortem studies which can be compared with those undertaken a generation ago; but African physicians in these countries have no doubt that these changes are taking place especially affecting the more affluent classes many of whom are adopting western lifestyles and suffering the consequences.

What are the main factors? Dietary patterns in African middle classes approach those of the industrialized nations. As a result, their serum cholesterol levels are much higher than in the rural population, amongst whom CHD is extremely rare.

But it is the emergence and rapid increase of cigarette smoking that is primarily responsible for the growing numbers of cases of lung cancer. Smoking is also a principal factor in the rise in CHD mortality for those who can afford a western style of eating. In Africa, cigarette consumption went up by 42% between 1970 and 1985 compared with a world growth of 7.1% and a fall of 25% in the United Kingdom. In Kenya consumption rose by 40% between 1970 and 1980. One of the major multinational companies made a profit of £ 53 million from its 11 African subsidiaries in 1989, an increase of 61% since 1986.

But there are signs of hope. Sudan, Nigeria, Mozambique and the Libyan Arab Jamahiriya have all banned tobacco advertising. Voluntary tobacco control groups have been formed in Sudan, Kenya, the United Republic of Tanzania, Uganda, Zambia, Nigeria and South Africa and concerned doctors and health workers are active in several other countries.

NEWS BRIEF

SHERATON: NON-SMOKING ROOMS ON THE INCREASE

In response to growing demand from their clients, the Sheraton hotels of Canada and the United States have increased the proportion of *"non-smoking"* rooms. As of 1 January 1991 all the North American establishments in this chain must reserve at least 25% of their rooms for the *"non-smoker"* category, as compared with only 10% previously. This measure reflects a sharp fall in the popularity of cigarettes in that part of the world, as a member of the Sheraton management says, pleased not only to satisfy the demands of the clientele but also to provide in so doing *"an environment that is even healthier and safer"*.

ECONOMICS

HONG KONG'S MASSIVE TAX INCREASE 8 MARCH 1991

In March 1991 the tobacco companies in Hong Kong were reported "*stunned*" by the massive and unexpected 200% increase in the rate of tobacco duty announced by Hong Kong's Financial Secretary.

On the day of the announcement the ***South China Morning Post*** reported that "*Smokers flocked to the stores in panic and the cigarette industry howled in anguish after the biggest tobacco bombshell in Kong Kong history. Manufacturers said that the 200% increase in tobacco tax was 'outrageous' and claimed they were the victims of blatant discrimination.*" However, the reaction of most smokers was one of resignation and a newly determined effort to quit.

The cost of a packet of 20 cigarettes thus increased from US $ 1.50 to between US $ 2.50 and US $ 3.00. And, for the first time in Hong Kong's history, the Government stated that this increase was for health, not fiscal, reasons. The Financial Secretary, in announcing the news, said: "*It has been put to me persuasively that for health reasons a hefty increase is now justified. So, with a particular view to reducing the attractiveness of smoking to young people, I am proposing an increase of 200% in the rate of duty. Incidentally, although the proposed increases are for health and not for fiscal reasons, it has not escaped my notice that the estimated additional revenue yield after allowing for consumer resistance will be about HK $ 1.9 billion.*"

Public and media interest has been intense. The health concerns have been emphasizing the beneficial effect of this increase, especially among the young and the poor. They have also supported this commendable public health action by the government.

The Hong Kong Government took a tremendous battering from the tobacco companies for this move and it is a compliment to it that the 200% tax increase has been maintained in spite of repeated demands by the vested interests of the tobacco industry for the increase to be revoked.

In the Legislative Council, Hong Kong's Secretary for Health and Welfare noted that the World Health Organization has estimated that smoking accounts for 90% of all lung cancer, 75% of chronic bronchitis, and 25% of coronary heat disease, as well as causing and contributing to many other illnesses. In addition, passive smoking causes both minor and major health problems, including cancer, in non-smokers. Thus, the expected reduction in smoking will translate into the preservation of health and life, with attendant saving of substantial human, social and financial costs to individuals and to the community.

Hong Kong has been overwhelmed by letters of support and commendation for the 200% tax increase from international, regional and national health organizations, economists, legal experts and others. These include the Presidents of the prestigious Royal Colleges of Physicians of London and Edinburgh; the World Health Organization; the International Union Against Cancer; the International Union Against Tuberculosis and Lung Diseases.

The price increases now are already in place, the tobacco industry estimates a 50% drop in smoking already. This will be closely monitored over the next few months and years.

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Latest update

In mid-May 1991 the Hong Kong Government had to revise its earlier 200% tobacco tax increase downward to a 100% increase; this is the first time in Hong Kong that a budgetary measure has ever been changed.

Among the reasons offered to justify the decision was concern about the inflationary effect of the 200% increase and its effect upon the consumer price index but as only 13% of the whole population smoke in Hong Kong, the increase is not inflationary in the same sense as transport, food or housing increases would be.

While on first inspection this may appear to be a victory for the tobacco industry and an embarrassing retreat for the health concerns, the gains are, in fact, still substantial:

- A final 100% tobacco tax increase has been achieved.
- The publicity generated was enormous, enabling the dissemination of essential information on the dangers of tobacco smoking and the tactics of the tobacco lobby.
- Hopefully many smokers who quit two months ago will not re-start.
- There may be, in fact, a greater chance of success for other smoking-control measures. Some Legislative Councillors emphasized the harmfulness of smoking and recommended that the pending package of comprehensive anti-tobacco legislative proposals should now be passed as soon as possible, and also that funding for health education should be stepped up.

NEWS BRIEF

BIG MAC AGAINST TOBACCO?

Caught in the crossfire between gourmets and nutritionists, the hamburger will, however, be contributing to a healthy way of life in the near future. The consumers of these big sandwiches may soon feel they are taking part in a health campaign, at least against the ill-effects of tobacco. MacDonald's, the biggest international fast-food chain, seems to be considering banning smoking from its establishments.

First, in the United Kingdom, where two of its hamburger outlets banned smoking a few months ago. Since the measure was very well received by clients, especially by families with young children, the managers of the chain are now thinking of extending it to other restaurants. Then in Hong Kong the MacDonald's fast food restaurants chose World No-Tobacco Day, 31 May 1991, as the date from which their restaurants would be smoke-free. In view of the popularity of the fast-food chain with children and young people, if all the MacDonald's outlets in the world, from San Francisco to Tokyo via Moscow, were to do the same, this would be a most important move in the campaign against smoking in public places.

READEX FICHE

FORTY-FOURTH WORLD HEALTH ASSEMBLY

INTERIM REPORT BY THE DIRECTOR-GENERAL ON THE WHO PROGRAMME ON TOBACCO OR HEALTH

The report of the Director-General to the Forty-fourth World Health Assembly in May 1991 covered a number of essential issues:

- the main "*tobacco or health*" problems and the response of WHO;
- a review of the economic and health consequences of tobacco production and consumption;
- the protection of health from the effects of world trade in tobacco products.

The report briefly presented the induced diseases, mortality and projections related to tobacco use (see ***Tobacco Alert*** of January 1991), the main orientations of the WHO Tobacco or Health programme and the role of WHO Member States in this field. The document also offered a short summary of activities carried out by WHO in relation to the impact of tobacco production in countries depending on tobacco as a major source of income with the specific case of Malawi as an example.

The large number of delegates who took part in the corresponding debate reflects the interest of WHO Member States in the issues related to tobacco or health, albeit in different fields of concern.

Most speakers were alarmed at the toll of ***tobacco deaths*** in the world in the 1990s and the need to address more aggressively the issue in developing countries. Even though it was gratifying to know that tobacco consumption had decreased in industrialized countries (partly as a result of governments following policies recommended by WHO), a large number of delegations expressed concern about the increase in tobacco consumption, as a result of the marketing strategies by multinational tobacco manufacturers, in developing countries and more recently in Eastern Europe; it was often and clearly indicated that the Organization should strengthen its efforts to make the reduction of tobacco use a priority in these countries.

Speakers also indicated their ***countries' determination*** to pursue tobacco-control programmes and activities as such were making a real contribution to the health of their population.

One delegate proposed that WHO join with other United Nations' agencies and with multinational tobacco manufacturers for the purpose of drawing up ***a special code of marketing for tobacco products*** with the aim of reinforcing other effective control measures such as legislation and public information. However, in the ensuing debate other speakers sounded a note of caution based on their national ex-

perience on trying to negotiate between the tobacco industry and the health sector. The idea was therefore reflected upon and it was concluded that it was difficult to advise the Organization to enter into a discussion about a product which in scientific terms had no safe threshold.

A resolution (WHA44.26) on ***smoking and travel*** was adopted by consensus; the following are the operative paragraphs:

THE FORTY-FOURTH WORLD HEALTH ASSEMBLY

1. **URGES all Member States:**
   1) to adopt appropriate measures for effective protection from involuntary exposure to tobacco smoke in public transport;
   2) to ban smoking in public conveyances where protection against involuntary exposure to tobacco smoke cannot be ensured, and to adopt effective measures of protection wherever possible;
   3) to promote educational activities necessary to make people aware of the importance of protecting themselves and their families, especially children, against passive smoking, for example, while travelling in private cars;
2. **REQUESTS the Director-General:**
   1) to collaborate with the International Civil Aviation Organization and all competent international and national agencies in developing guidelines and recommendations for a smoke-free travel environment in all types of public conveyances;
   2) to support Member States at their request in implementing effective measures to protect against involuntary exposure to tobacco smoke in public transport;
   3) to keep the Executive Board and the Health Assembly informed of the progress made in implementing this resolution as an element of the WHO tobacco or health' programme."

During the debate another draft resolution on the ***social and economic issues of tobacco or health*** had been proposed. This triggered a debate on the role of WHO regarding tobacco production and consumption. It was said that the limits of WHO's action, given its limited resources, must be carefully defined. It was recognized that WHO had already done, as demonstrated by the report of the Director-General, all that its mandates allowed to assist tobacco-dependent economies.

Yet, what about the few countries depending on tobacco production for their economic and health development? For their sake important matters such as crop substitution, agricultural diversification and economic support must not be neglected; unfortunately they led outside the remit of the Health Assembly and the activities of the Tobacco or Health programme whose goal must be the lessening of tobacco-related health problems through reduced tobacco use. It was thus important, at this stage, to ensure that these issues be discussed in the ***appropriate competent fora*** in the United Nations system, e.g. FAO, ILO, UNIDO, UNCTAD, and GATT governing bodies, who would need to formulate their own resolutions on the subject. As a step in this direction the Director-General of WHO proposed to include the tobacco issue in his report to the forthcoming meeting of the Economic and Social Council of the United Nations (ECOSOC) in July 1991. All participants in the debate approved the Director-General's proposal and the sponsors of the draft resolution agreed to withdraw it.

Despite some obvious conflicts of interest that emerged during the debates, all decisions and resolutions were adopted by consensus, which reflects the unanimity that has been reached throughout the world on the essential issues of tobacco control.

ENVIRONMENT

UNDER THE CIGARETTE-ENDS, THERE'S A BEACH

Each year, thousands of volunteers spend one day cleaning the famous Chesapeake Bay, in the United States, to preserve the environment of this site which is dear to walkers and bathers. The list of what they pick up there is not especially edifying: whereas the lion's share of the collected garbage is all kinds of plastic, cigarette filters come just after bits of paper in terms of number of items picked up. Here are the figures: in 1989, some 2 000 volunteers cleaned more than 80 km of coastline, gathering about 30 tons of rubbish of all kinds, including 8 894 pieces of paper (9% of the total), 7 144 cigarette butts and filters (7.3%), 6 972 pieces of glass, 5 642 empty beer or soft-drink cans and 5 591 unidentified pieces of plastic, to name only the most important items on the list. Nevertheless, the omnipresence of cigarette butts on one of the most frequented beaches of North America contrasts starkly with the image of pristine nature which the tobacco industry is fond of using in its advertising.

NEWS BRIEF

UNITED KINGDOM: NO MORE DEVELOPMENT AID FOR TOBACCO!

The British aid programme will no longer support the tobacco sector in developing countries. This was announced by Mrs Lynda Chalker, Minister for Overseas Development, in reply to a parliamentary question. *"Tobacco remains an important crop and a source of export earnings and budgetary revenue in some developing countries"*, states the Minister. *"There is however increasing evidence that the health risks associated with tobacco consumption will affect developing countries most severely, and place increasing burdens on their health budgets which in most cases are already inadequate. In these circumstances, the Government have decided that in future the aid programme should not be used for any purpose which identifiably supports the tobacco sector. In addition"*, the Minister went on, *"we shall continue to help developing countries reduce their tobacco consumption, and maintain our assistance to farmers dependent on tobacco crops to diversify into alternative activities. The same policy will apply to our assistance to eastern Europe"*.

This policy change means that any requests for British aid which can clearly be identified as going towards producing or processing tobacco will be categorically refused. The Minister admits, however, that in some cases, such as aid for fertilizer imports, it will be very difficult and sometimes impossibly to identify its final use.

LEGISLATION

LEGISLATION IN FRANCE

The law on control of smoking and alcoholism, which was passed by the French Parliament on 10 January 1991, follows on from the law of July 1976 against smoking, which unfortunately had not been systematically applied. Its main provisions are measures designed to reduce the effects of an epidemic which, in France, causes approximately 15% of all deaths, half of them premature, and is an essential cause of social inequality in the face of disease and death. The epidemic is striking increasingly early in life, and both sexes equally, since people begin to smoke earlier (10% smoking regularly at about 11 years of age), and more women are starting to smoke.

The main sections of the law of January 1991 deal with advertising, pricing of tobacco products, banning of smoking in enclosed public places, information and health education, and maximum tar levels for cigarettes. The measures are in line with World Health Organization recommendations, and with the directives of the European Community.

As regards tobacco advertising, whose annual budget is around one billion French francs, there is to be a total ban on all forms of advertising, direct and indirect, including sponsorship, as of 1 January 1993. The ban applies to the use of graphics, presentation, brand names, publicity emblems or any other distinctive sign recalling tobacco or a tobacco product.

The sale price of cigarettes, which comes into calculation of the consumer price index, has been kept artificially low in France (approximately half the average price charged in the 12 Member States of the European Community) in order to contain the rate of inflation. There will be a 15% price increase in autumn 1991. The law of 10 January 1991 excluded the price of tobacco from calculation of consumer price indexes as of 1 January 1992. The Council of Ministers of 28 March 1991 went back on that provision: two indexes will be published - one with and one without tobacco - the latter for use in the main salary negotiations. This should allow for large and repeated increases in the price of cigarettes, so as to reduce smoking among young people.

Section 16 of the law states that smoking is banned in public premises, especially schools, and in public transport, except in areas especially reserved for smokers. The principle of the Section, which should be the subject of a decree in mid-1991, is that in enclosed spaces for the public, including workplaces, the rule should be that there is no smoking, and that specific areas should be allocated for smokers.

Maximum levels of tar, which are still very high in France (some varieties of very common brands of cigarettes contain as much as 22-24 mg), have to be limited to Community standard levels (15 mg per cigarette as of 15 January 1993, 12 mg as of 1998).

A set of measures will be taken to implement the main provisions of the legislation. These include warnings on cigarette packets (*"smoking causes cancer"* and *"smoking seriously damages health"*), information and education campaigns in schools, the media and associations, use of proven methods for stopping smoking, and involvement of health and education professionals.

Finally, the application of the law will be the subject of two evaluation reports on 1 January 1993 and 1 January 1995.

LEGISLATION

SOME RECENT LEGISLATIVE DEVELOPMENTS

The Health Legislation unit at WHO headquarters is continuing to monitor and disseminate information on significant national and subnational legislation that with the *"tobacco or health"* issue. The following are some highlights of recent activity in this area.

AUSTRALIA

Half of the states and territories of Australia have enacted comprehensive legislation to control the sale and promotion of tobacco products and to use revenue raised by taxes on tobacco for Health Promotion Foundations which support sports, cultural activities, and other purposes. The relevant statutes are as follows: the Victorian Tobacco Act 1987, the South Australian Products Control Act 1988, the Australian Capital Territory Tobacco (Amendment) Act 1990, and the Western Australian Tobacco Control Act 1990.

The objectives of the Western Australian statute are stated to be:

- the active discouragement of the smoking of tobacco by:
  - (a) encouraging non-smokers, particularly young people, not to start smoking;
  - (b) limiting exposure of children and young people to persuasion to smoke; and
  - (c) encouraging and assisting smokers to give up smoking;
- the promotion of good health and the prevention of illness.

CANADA

A comprehensive Smoking and Tobacco Products bill has been drafted in the Province of Prince Edward Island by a Legislation Committee and is on the agenda at the Spring Session of the Legislature of the Province. It addresses: smoking in public places; smoking in the workplace; and the sale of tobacco products to minors (including the licensing of tobacco outlets).

CHINESE PROVINCE OF TAIWAN

An Executive Order has been signed which establishes a five-year plan for the prevention of smoking and the control of tobacco use. This plan, which covers the period 1990-1995, includes a section dealing with legislation. The plan envisages a ban on smoking in public places, a prohibition on the advertising and promotion of cigarettes, and a modification of the warning notices on cigarettes to address specific health problems .

FRANCE

See article entitled *"Legislation in France"* on page 6.

UNITES STATES OF AMERICA

Rules issued by the Interstate Commerce Commission in January 1991 prohibit smoking in all scheduled intercity passenger-carrying motor vehicles.

MOROCCO

A strong anti-tobacco law was adopted at the end of April 1991 by the Legislature. It imposes a ban on smoking in public places and prohibits advertising for cigarettes in official means of communication and in public thoroughfares.

NEWS BRIEF

TOBACCO GETS UNDER MY SKIN ...

This is how smokers – and non-smokers – sometimes describe the effect smoking has on them, and it may not be very far from the truth according to a scientific study of the effects of smoking on the skin published recently in the ***Revue européenne de dermatologie***. There is still discussion as to whether women who smoke have more wrinkles than those who do not, but it is quite certain that many disorders of the skin and mucous membranes are associated with smoking: yellowed fingers and nails, aggravation of pre-existing skin diseases especially in the mouth, pre-cancerous and cancerous lesions of the mucosa of the lips and mouth, to mention only some of the more striking. It has also been established that smoking disrupts the microcirculation of the skin and that certain epithelia may display immune disorders associated with smoking, reports the author of the study, Dr Albert-Adrien Ramelet. Certainly, he goes on to say, *"more thorough studies need to be carried out to define more precisely the dermatological injuries caused by smoking. But in the meantime the dermatologist can encourage smokers to cut down or stop smoking, since its harmful effect on the blood vessels and the viscera is well established"* – to prevent the smoke from having their hide, so to speak.

IARC/EPIDEMIOLOGY

TOBACCO SMOKING AND THE RISK OF ORAL CANCER IN CHINA

Oral cancer is the eighth commonest form of cancer internationally, with high rates in some of the developing world and increasing rates among younger people in many developed countries. Oral cancer is particularly common in the Indian sub-continent, where in certain regions it can attain fifty per cent of all tumours diagnosed. In the developed countries, incidence rates are particularly elevated in parts of France. As currently understood, the most important risk factors for the occurrence of oral cancer are tobacco smoking and alcohol consumption in Western countries and chewing tobacco and betel in the Indian sub-continent.

In China, tobacco and betel chewing are rare and are only frequent on Hainan Island and the Province of Taiwan. However, tobacco smoking and alcohol drinking are both popular habits. According to some recent surveys, more than 70% of men and 8% of women aged more than 20 years smoke cigarettes. There have been few formal epidemiological studies of oral cancer in Asia and none in China. Thus, an epidemiological study using a case-control design was undertaken in Beijing to investigate risk factors for oral cancer including tobacco smoking and the related habit of alcohol consumption. For the purposes of this study "*oral cancer*" was defined according to rubrics 141 and 143-145 of the International Classification of Diseases Ninth Revision, i.e. cancers of the tongue and mouth (gums, cheek, hard and soft palate, etc.).

A total of 404 cases were identified and interviewed in seven participating hospitals in Beijing: the National Cancer Hospital, Beijing Union Hospital, Beijing Stomatological Hospital, Stomatological Hospital of Beijing Medical University, Tongren Hospital, Tian Tan Hospital and Beijing 301 Hospital. Participation of cases and their matched hospital controls was 100%. A smoker was defined as someone who had smoked 100 cigarettes, or cigarette equivalents (1 cigar = 2 cigarettes; 0.8 g tobacco = 1 cigarette), before diagnosis and a current smoker was defined to be someone who had smoked within the year preceding diagnosis.

A clearer pattern was available for males, who represented the majority of the cases (248/404, i.e. 61%), since a larger proportion of them were ever-smokers (58% of controls) than females (10% of controls). The results which follow only refer to males and have been adjusted for age, sex, years of education and alcohol consumption.

Life-long smokers had a two-fold risk of oral cancer compared to lifelong non-smokers. Compared to lifelong non-smokers, the risk in current smokers was 2.4 (95% Confidence Interval (1.5, 4.0)) while the risk in ex-smokers was 1.1 (0.6, 2.1). Three measures of level of exposure to tobacco (cigarette equivalents smoked per day, years smoked and pack-years smoked) all showed statistically highly significant exposure-response relationships: the risk in those who reported the highest lifetime consumption was 3.7 (1.8, 7.4) relative to non-smokers. For all three measures of exposure, tests of linear trend by conditional regression analysis after adjustment for the confounding variables described in the previous paragraph were all statistically significant at the level of $p < 0.001$.

Pipe smokers had almost three times the risk of those who smoked cigarettes exclusively: compared to lifelong never smokers of tobacco, the relative risk for those who smoked only pipes was 5.7 (2.4, 13.3) while that among men who smoked only cigarettes was 1.6 (1.0, 2.6). When analysed in more detail, a stronger effect was retained for pipe smoking than cigarette smoking although the latter remained significant even after adjustment for pipe smoking. The risk was stronger for squamous carcinoma than for other histological forms of the disease.

Although the number of smokers among female controls was small, the findings in females were essentially similar to those in males. If the associations observed in this study are causal, it can be estimated that tobacco smoking accounts for 34% of all cases of oral cancer in this population: 45% among males and 21% among females.

Thus, this first analytical epidemiological study of oral cancer in China has shown a strong association between oral cancer risk and tobacco smoking, whether in the form of pipes or cigarettes. The important implication is that a large proportion of oral cancer in China, or in Western countries, could be avoided by reductions in tobacco smoking.

WORLD NO-TOBACCO DAY 1992

SMOKE-FREE WORK PLACES

The next World No-Tobacco Day will be celebrated on 30 May 1992; the theme will be: "*Smoke-free workplaces*". Preparation of information material for the celebration of the day has already commenced in the Tobacco or Health programme at WHO headquarters where any information that could illustrate the theme from the scientific, political or legislative standpoints will be gratefully received. Please forward any information which you consider to be of interest to the Editor of Tobacco Alert.

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